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No. 95-1929

In The

Supreme Court of the United States

October Term, 1995

MARY McCABE, as Administratrix of the Estate of Ruchla "Rose" Zinger,

Petitioner,

v.

THE CITY OF LYNN,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The First Circuit

MOTION FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE* AND BRIEF OF THE MENTAL HEALTH LEGAL ADVISORS COMMITTEE, THE BAZELON CENTER FOR MENTAL HEALTH LAW, AND COMMISSION ON LAW AND SOCIAL ACTION OF THE AMERICAN JEWISH CONGRESS, NEW ENGLAND REGION, IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE* OF THE MENTAL HEALTH LEGAL ADVISORS COMMITTEE, THE BAZELON CENTER FOR MENTAL HEALTH LAW, AND COMMISSION ON LAW AND SOCIAL ACTION OF THE AMERICAN JEWISH CONGRESS, NEW ENGLAND REGION

The Mental Health Legal Advisors Committee, the Bazelon Center for Mental Health Law, and Commission on Law and Social Action of the American Jewish Congress, New England Region, move for leave to file the accompanying brief *amicus curiae* in support of Mary McCabe's petition for a writ of certiorari from the judgment and opinion of the United States Court of Appeals for the First Circuit.

Pursuant to Supreme Court Rule 37.2, consent of the parties to the filing of the brief was sought through counsel. Counsel for the petitioner gave consent, but counsel for the respondent City of Lynn declined to give consent.

INTEREST OF AMICI

The first two listed organizations seeking to file this brief *amicus curiae* have experience with Fourth Amendment issues in general, and, in particular, with the special legal problems of individuals who have been diagnosed with, or are perceived to have, mental illness. Resolution of this case will directly affect the clients and staff of these organizations, and the attorneys who depend on them for assistance. The third listed organization has a long history of working to protect the civil and human rights of all.

The Mental Health Legal Advisors Committee (MHLAC) is a statutory agency of the Commonwealth of Massachusetts, operating under the jurisdiction of the Supreme Judicial Court and with the explicit "duty . . . to assist and advise indigent patients and residents in . . . mental health . . . facilities of the commonwealth." Mass. Gen. L. ch. 221, § 34E. In that capacity, it provides advice and assistance to individuals with mental illness throughout Massachusetts, to their families and friends, and to other attorneys. MHLAC also has "the duty . . . to conduct a continuing program of information with regard to the legal rights of patients and residents at all mental health . . . facilities in the commonwealth," *id.*, and, accordingly, writes, publishes, and distributes pamphlets, handbooks, and a semi-annual legal journal, and provides training, to judges, lawyers, legislators, individuals, organizations, and the staffs of mental health facilities. As an aspect of these obligations, MHLAC acts to monitor legal issues, especially those involving human rights, affecting Massachusetts citizens who are caught up in the state's mental health system.

With over 2,000 requests for assistance annually logged at MHLAC, its attorneys regularly assist individuals (or their attorneys) who have been involuntarily committed pursuant to Mass. Gen. L. ch. 123, § 12 or who are threatened by such a commitment. As a consequence, much of their effort, in their roles both as advocates and as monitors, is directed at the numerous issues surrounding the commitment process.[1] This litigation will therefore have a direct impact both on the individuals whom

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[1] *See, e.g., D.L. v. Commissioner of Social Services*, 412 Mass. 558, 559 n.3 (1992); *Taunton State Hospital v. LaPlante*, 40 Mass. App.Ct. 1124 (1996), *application for review pending*, No.

MHLAC serves and on the MHLAC advocates who attempt to provide assistance to this client group.

The Bazelon Center for Mental Health Law (the Bazelon Center) is a Washington, D.C.-based public interest organization founded in 1972 to advocate for the rights of children and adults with mental illness. It has brought major cases decided by this Court establishing the rights of people with mental disabilities, and has participated as *amicus curiae* in this Court in more than a dozen additional cases. Its advocates devote considerable time to commitment issues; this includes responding to numerous inquiries from individuals about commitment proceedings, systemic reform efforts geared towards deinstitutionalization of individuals committed to state facilities, and work on cases directed at correcting abuses in the commitment process.

The American Jewish Congress (the AJCongress) is an organization committed to the principle that the destinies of all Americans are indissolubly linked and that any act which unjustly injures one group necessarily injures all. Out of this firmly held belief, the AJCongress created its Commission on Law and Social Action in 1945, in part "to fight every manifestation of racism and to promote the civil and political equality of all minorities in America."

Believing that Jewish interests are inseparable from the interests of justice, the AJCongress cannot remain

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FAR-08564 (Mass. Supreme Judicial Court, filed June 14, 1996); *see also* Jennifer Honig, *An Unexpected Admission*, 44 ADVISOR 1 (Spring 1996).

impassive or disinterested when persecution, discrimination, or humiliation is inflicted upon any human being because of his or her race, religion, color, national origin, gender, or ancestry. The persecution at any time of any minority portends the shape and intensity of persecution of all minorities. The same broad principles apply to persons alleged to be mentally ill.

Furthermore, the special concern of the Jewish people for human rights derives from an immemorial tradition which proclaims the common origin and end of all mankind and affirms, under the highest sanction of faith and human aspirations, the common and inalienable rights of all persons. The struggle for human dignity and liberty is thus of the very substance of the Jewish tradition. And the sanctity of the home against arbitrary lawless intrusion is fundamental to that tradition's concepts of human dignity and liberty.

REASONS FOR GRANTING THE MOTION

This case claims a violation of the Fourth Amendment's prohibition against the warrantless entry and search of a private residence in a civil matter. The estate of the individual who died when the respondent City of Lynn's police served an involuntary commitment order signed by a physician seeks damages pursuant to 42 U.S.C. § 1983. Although the *amici* have no doubt that the petitioner and her counsel will continue vigorously and effectively to pursue this matter, the Court should grant this motion and order the brief *amicus curiae* to be filed in order to obtain the experience and broader perspective which these organizations bring to the matter.

As the previous section discusses, *amici* are intimately and regularly involved with the specific and general issues raised by this case. They frequently advise or refer individuals who are subject to involuntary commitment orders and who are consequently seized and incarcerated without benefit of a warrant. The events which led to this case, especially the death of Rose Zinger, graphically demonstrate the perils of that course of events. The extreme nature of the result in this instance, however, should not belie the fact that, as the brief *amicus curiae* demonstrates, there is a compelling need for a warrant requirement in involuntary commitments regardless of the harm occasioned in a particular case.

The accompanying brief shows that the situation described in the petition, while especially tragic in its outcome, depicts a result which should be wholly expected when the discretion to order enforcement of an involuntary civil commitment rests solely with medical personnel. Accordingly, the Mental Health Legal Advisors Committee, the Bazelon Center for Mental Health Law, and Commission on Law and Social Action of the American Jewish Congress, New England Region, request that the Court grant this motion to file their brief in support of the petition for certiorari.

Respectfully submitted,

GILL DEFORD
JENNIFER HONIG

June 1996

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INTEREST OF AMICI

The interest of *amici* is set forth in the accompanying motion for leave to file this brief.

REASONS FOR GRANTING THE WRIT

In many instances involving involuntary commitments, individuals are subjected to humiliating and improper search, apprehension, and incarceration, but the harm is not so apparent or egregious that the legal system is able to, or could be expected to, provide a remedy after the fact. Furthermore, there is little or no chance of effecting the equitable remedy of release prior to the end of the temporary commitment. As a consequence, most individuals who are victimized by involuntary commitments have no practical legal recourse.[1] This case is unusual, therefore, because the harm was so extreme and obvious, and the municipal policy which led to that harm so clearly set out, that the legal system could provide a remedy, and, accordingly, there were attorneys willing to represent the victim.

The critical point for purposes of this petition, though, is that involuntary commitments frequently implicate civil rights violations, and the lack of a warrant requirement increases the likelihood of those violations. This case, while thus unusual in the extremity of the physical harm and in the opportunity to seek restitution for that harm, is not unusual in the nature of the rights

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[1] *See* Lynne Valenti, *Section 12 Admissions – The Problem with Remedies*, 41 ADVISOR 7 (Fall 1994).

violated, as the examples presented later in this brief (at 10-17) will show. In this larger context, the case is significant for its ability to demonstrate the defects in a system which allows search, seizure, and incarceration without a warrant.

In order to ensure that other instances of Fourth Amendment violations are not evaded, therefore, the Court should grant this petition. It goes without saying that the death of Rose Zinger was a tragedy that should never be repeated. By reviewing and reversing the decision of the Court of Appeals, however, this Court will not only decrease the likelihood of physical harm in future involuntary commitments, but will also help to prevent all violations of the Fourth Amendment occasioned in the involuntary commitment context – regardless of the nature of the harm.

I. THE FIRST CIRCUIT'S "ADMINISTRATIVE PURPOSES" ANALYSIS EVISCERATES THE FOURTH AMENDMENT'S WARRANT REQUIREMENT FOR INDIVIDUALS SUBJECT TO CIVIL COMMITMENT

Relying on key decisions of this Court, the court below purports to recognize the critical protections guaranteed by the Fourth Amendment:

> Nonconsensual entries by government agents into a residence without a warrant are presumptively "unreasonable" under the Fourth Amendment. . . . This presumption is designed to safeguard the special privacy expectations traditionally recognized in the American home by requiring that a "neutral" and detached judicial

> officer make an independent assessment as to whether law enforcement agents have probable cause to effect an intended search or arrest within the home.

McCabe v. Life-Line Ambulance Service, Inc., 77 F.3d 540, 544 (1st Cir. 1996) (Pet. 9a) (citations omitted). Despite this recognition, however, the First Circuit concludes that the Fourth Amendment is not violated when police officers invade a private home based solely on the signature of a doctor or nurse who has neither conducted an examination of the individual to be committed nor held a hearing to evaluate the evidence.

The appellate court's leap from the basics of Fourth Amendment jurisprudence to its extraordinary conclusion is explicitly *not* premised on the one recognized exception to the warrant requirement for a residential search, the existence of exigent or emergency circumstances. *Id.* at 546 (Pet. 13a). Rather, the court below relies on a line of decisions which, in carefully limited and discrete circumstances, obviate the need for a warrant when the search is "conducted in furtherance of an important administrative or regulatory purpose, or 'special need,' which would be undermined *systemically* by an impracticable warrant or probable-cause requirement." *Id.* at 545 (Pet. 10a), quoting *Griffin v. Wisconsin*, 483 U.S. 868, 873 (1987). Consequently, according to the Court of Appeals, the specific events of this case – breaking down a residential door, forced entry into the home of a terrified survivor of the Holocaust, the handcuffing and

violent removal of the individual, and her consequent death[2] – are all irrelevant: "[A] 'special need' search procedure policy . . . must focus not on the particular case but on the essential systemic attributes of the search procedure itself . . . . " *McCabe*, 77 F.3d at 549 (Pet. 21a).

The First Circuit's reliance on this Court's "administrative purpose" or "special need" decisions is a significant departure from the premises of those decisions, ignores or understates their markedly different circumstances, and represents a drastic diminution in the Fourth Amendment's guarantee of residential privacy. That line of authority has several variations, but none can be stretched to cover this situation. Thus, this is not comparable to a social worker's home visitation on which eligibility for welfare is premised and which the recipient may simply refuse, a condition which negates any Fourth Amendment implications or protections. *Wyman v. James*, 400 U.S. 309, 317 (1971). Nor is it a search outside the home, where the expectations of privacy are considerably reduced. *See O'Connor v. Ortega*, 480 U.S. 709, 717 (1987) (search of public employee's desk); *New Jersey v. T.L.O.*, 469 U.S. 325, 340 (1985) (search of student's pocketbook on school grounds).

In its most dramatic departure from this Court's jurisprudence, however, the First Circuit purports to deduce support from the determination that warrantless home entry is permissible in the administration of a probation system. *Griffin v. Wisconsin*, 483 U.S. 868 (1987).

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[2] *See McCabe v. City of Lynn*, 875 F.Supp. 53, 57 (D.Mass. 1995) (Pet. 41a-42a), *rev'd sub nom. McCabe v. Life-Line Ambulance Service, Inc.*, 77 F.3d 540, 542-543 n.2 (1st Cir. 1996) (Pet. 4a-5a).

This analysis represents a basic misperception of the two situations. The critical premise of *Griffin*, as the First Circuit itself has previously recognized, is that "probation, as 'a form of criminal sanction,' disenfranchises the recipient of at least some rights enjoyed by law-abiding citizens, probation being 'simply one point . . . on a continuum of possible punishments . . . . ' " *United States v. Cardona*, 903 F.2d 60, 62 (1st Cir. 1990) (applying *Griffin* to administration of a parole system), *cert. denied*, 498 U.S. 1049 (1991), quoting *Griffin*, 483 U.S. at 874. Although the court below relies throughout on both *Griffin* and *Cardona* for its explication of the administrative purpose doctrine, and explicitly recognizes that this case raises Fourth Amendment issues in a civil setting, *see* 77 F.3d at 544 (Pet. 8a), it makes no attempt to explain how *Griffin* could apply in the civil commitment context where the determinative "criminal sanction" is lacking.[3]

Thus, in the absence of an emergency, this Court has countenanced the nonconsensual search of a home in only one situation, which was expressly premised on the ongoing loss of rights occasioned by a criminal conviction and punishment. The decision below thus dramatically

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[3] A telling omission follows the First Circuit's observation that "warrantless 'special need' searches have been condoned by the courts in circumstances where the State interests were far less compelling and urgent [than in the present situation]." 77 F.3d at 547 (Pet. 14a). The court below then describes three decisions of this Court, all of which approved warrantless searches carried out under the administrative purpose rubric – but in the non-residential context. The First Circuit does not mention *Griffin* in this discussion.

deviates from this Court's narrow exception to the prohibition against warrantless searches of private residences.

II. THE COURT OF APPEALS' DETERMINED RELIANCE ON CLINICIANS NOT ONLY MISCONSTRUES THE STATUTE, BUT, MORE IMPORTANTLY, MISUNDERSTANDS THE INSTITUTIONAL INADEQUACIES OF MEDICAL PERSONNEL IN ISSUING THE EQUIVALENT OF SEARCH WARRANTS

The reliance of the court below on the administrative purpose exception to the warrant requirement depends on two complementary assumptions: an uncritical acceptance of medical personnel as substitutes for judges, and a decidedly tepid faith in the actions of magistrates. On the latter point, the court states:

> More importantly by far, . . . the additional burdens imposed . . . by a universal warrant requirement in category 2 searches seem to us "undue" and "unreasonable" when viewed in relation to *the minimal additional protection afforded by a requirement that a pink paper be screened by a magistrate before it is executed.*

77 F.3d at 550 (Pet. 22a) (emphasis added). Similarly, in its rush to reject judicial review, the court both misconstrues the statutory scheme and ignores the fact that clinicians, by the nature of their training, practice, and ethical obligations, are not appropriate surrogates for magistrates.

A. The First Circuit misreads critical components of the involuntary commitment scheme.

As an initial matter, the appellate court misunderstands the integrated roles of medical personnel and magistrates which the legislature intended. The statute expressly contemplates that, in circumstances such as these, a judge should consider the evidence presented for involuntary commitment, and, only where appropriate, issue a warrant of apprehension, followed by a physician's examination. Mass. Gen. L. ch. 123, § 12(e) (Pet. 35a); *see McCabe v. City of Lynn*, 875 F.Supp. at 62 & n.11 (Pet. 53a). The Court of Appeals, however, inexplicably holds that, when a "pink paper" is signed pursuant to section 12(a) of Mass. Gen. L. ch. 123, the hearing and warrant requirement of section 12(e) are "implicitly" obviated. 77 F.3d at 548 (Pet. 17a). The court below thus begins its analysis by incorrectly assuming that the legislature did not intend magistrates to evaluate the propriety of enforcing commitment orders.

Secondly, in attempting to bolster its view of section 12(a) by infusing into it "reasonable safeguards" against "obvious abuse", 77 F.3d at 551 (Pet. 25a), the appellate court incorrectly states that

> a pink paper can be authorized *only by a licensed psychiatric physician* . . . whose extensive education and specialized experience and training should enable the *psychiatric physician* more reliably to parse such lay reports, especially those provided by family members, with the requisite professional skepticism.

Id. (Pet. 25a) (emphasis added; footnote omitted); *see also, e.g., id.* at 552 (Pet. 27a-28a) ("an involuntary 'category 2'

commitment rests with a licensed psychiatric physician"). In fact, the so-called "category 2" commitment order, by which an order to commit is issued without examination of the individual, may be signed by any of three clinicians: a "physician, qualified psychologist or qualified psychiatric nurse mental health clinical specialist." Mass. Gen. L. ch. 123, § 12(a) (Pet. 33a). However capable these clinicians may be, the court based its confidence in pink paper signatories on the incorrect assumption that they were "psychiatric physicians". In fact, however, they may be either physicians without psychiatric training, *see Reida v. Cape Cod Hospital*, 36 Mass.App.Ct. 553, 555-556, *review denied*, 418 Mass. 1105 (1994), or psychologists or nurses without medical degrees.

B. In evaluating the propriety of nonconsensual searches of private residences, medical personnel are not appropriate substitutes for judges.

The First Circuit's misreading of the statutory scheme, however, foreshadows a more fundamental error: its belief that a clinician evaluating the sole standard for temporary involuntary commitment – dangerousness – is a proper substitute for a magistrate balancing the factors relevant to issuing a warrant of apprehension. This assumption ignores the institutional deficiencies which medical personnel necessarily bring to the task – deficiencies related not to their dedication and intelligence, but, rather, to the inherent inadequacies and limitations of their training and viewpoint in the context of the essentially judicial duty which they are asked to perform. In addition, in many, perhaps most, instances, the medical personnel signing section 12 orders are not

government employees; therefore, they have not been charged with acting in the public interest, *see, e.g., Griffin*, 483 U.S. at 876, and are less likely to be familiar with traditional concepts of governance, such as due process.

i. Clinical training is not conducive to the balancing of interests required.

Clinicians are not prepared professionally to conduct the analysis which, as the instant case demonstrates, may result in a residential search by armed police officers. Their training directs them to review the psychiatric and medical interests of their clients, but not other personal concerns. In recent research presented at the Third Annual Conference on State Mental Health Agency Services Research and published by the National Association of State Mental Health Program Directors Research Institute, Inc., the clinician's perspective is presented as follows:

> [P]ersons who have experienced mental illness and received various treatment modalities and providers of those services perceived the world very differently. . . . Professionals are trained to focus on pathology and incapacity and to practice mental health care as a specialized intervention. Clients, on the other hand, have a more global world-view of mental health and recovery that encompasses the need to recognize and nourish personal strengths, respect choice and autonomy, and support a quality life. This oversight is particularly salient when researching the iatrogenic effects of mental health services and institutionalization and the impact of those effects on the lives of persons diagnosed with

> mental illness. Often, researchers lack the insight to ask questions that would capture detrimental effects of treatment and care. In a review of quality of life instruments, for example, I found no measure of personal freedom and decision-making power even though these factors represent deep-seated cultural values.

Jean Campbell, *The Well-Being Project: Mental Health Clients Speak for Themselves,* THIRD ANNUAL CONFERENCE PROCEEDINGS 21, 22 (1993) (citation omitted).

As indicated above, the clinician is trained to focus on the narrow issue of the patient's health (and also, perhaps, on the safety of others), but is not necessarily concerned with the individual's interests in non-clinical factors or with the larger interest of preserving and enforcing fundamental rights. By contrast, a magistrate's background demands appreciation of the importance of individual interests in non-clinical factors and in conducting analyses that account for such interests.

An example reveals how the clinical evaluation conducted prior to the signing of a pink paper does not involve the balanced review which a magistrate would employ.[4] In June 1995, Larry, who was sixteen, and his father were touring a psychiatric hospital. Larry had emotional problems and a form of autism, but was currently living with his family and attending school. At the conclusion of the tour, a nurse asked Larry to answer some questions. When asked if he ever wanted to hurt or

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[4] The names of the individuals discussed in the following examples have been changed, but each has given permission for presentation of his or her story.

kill himself, Larry explained that, while he could imagine wanting to do so at some future point if he believed that he would never have a normal life, he did not presently desire to injure himself. The nurse consulted with a psychiatrist, who then informed Larry's father that Larry had to stay at the hospital. Despite his father's objection that the psychiatrist had not talked with his son, Larry was held at the facility. Extremely upset and agitated by this news, Larry was thrown to the ground, wrapped in a papoose-like covering, and placed in a darkened room. In reaction to this outburst, the crisis team then issued the order for admission.

In determining that Larry should be admitted, the psychiatrist apparently reviewed his clinical condition, as conveyed to him by the nurse, but did not consider Larry's personal preferences. Clinicians' evaluations for purposes of involuntary admissions will often take this narrow approach, which lacks a careful balancing of a range of public and private interests and focuses entirely on the perceived psychiatric state of the individual. It is precisely because of this narrow clinical approach that the broader perspective of the legally trained magistrate should take precedence.

ii. Influences largely peculiar to the clinician-patient relationship may incline clinicians to sign commitment orders.

A clinician's personal feelings about a patient may be a factor leading to the decision to issue an admission

order.[5] Thus, for instance, a clinician may be disturbed by the patient's attitudes or behaviors in the context of therapy. Even doctors and patients who work together for long periods of time will have disagreements in the course of treatment, which may incline the doctor in favor of signing a pink paper.

A recent example illustrates this possibility. In October 1995, Annette was experiencing wildly fluctuating blood sugar levels induced by diabetes and was unsure if she was having an anxiety attack or a heart attack. Speaking with a psychiatric nurse at her hospital's outpatient clinic, where she was well known, Annette denied being suicidal or at risk of self-injury. While Annette remained in a chair, crying from the stress of the anxiety attack which had initiated her visit to the hospital, the nurse conversed with the clinic's chief psychiatrist on the other side of a glass window. Without entering the room to speak with Annette or attempting to contact her physician, psychopharmacologist, or therapist, the chief psychiatrist issued a section 12 order.

Annette believes that this decision was driven by the chief psychiatrist's negative feelings towards her deriving from a previous disagreement over the course of her treatment. Her own psychiatrist had challenged the chief

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[5] The First Circuit offers in support of its position that "many, if not most, category 2 searches are executed pursuant to pink papers issued by the subject-patient's current or former psychiatric physician." 77 F.3d at 553 n.13 (Pet. 29a). There is no evidence for this statement. In any event, the argument is ironic, because, as the following discussion indicates, the clinician-patient relationship may actually prejudice the clinician in favor of commitment.

psychiatrist by confronting him and criticizing his earlier decision. When she and the chief psychiatrist did speak after the section 12 order was signed, Annette could sense his hostility; riding the elevator with him to the locked ward, he told her that, if she did not go quietly, he would put her in four-point restraint.

In addition, clinicians have professional liability concerns which influence their actions. In marginal cases, these fears may induce a clinician to issue an order for admission, as apparently happened in the following recent instance.

In April 1996, Mishi went to see her neurologist for a brief visit. To the neurologist's inquiry about her depression, Mishi replied that she was doing no better and no worse than before. With no further discussion, the neurologist then stated that she was arranging for Mishi to have an evaluation at a nearby private hospital. The neurologist telephoned the hospital, stating that Mishi was on the way, that she would likely deny everything, and that they should hold her for an evaluation. At the hospital, Mishi provided a nurse details about past experiences; the nurse did not ask about Mishi's present condition. Mishi was then told that she would have to stay at the hospital for the night and that, if she tried to leave, she would be forcibly held. Over the course of the night, Mishi explained to four doctors that she was not experiencing any problem and that there was no reason to detain her. In the morning, she was released.

In this case, a series of clinicians, including Mishi's neurologist, the nurse, and several doctors were all reluctant, even absent any evidence of present danger, to

release her. The logical inference is that no one individual would take responsibility for her, thus forcing her to gain her freedom only by convincing six different individuals that there was no basis for incarceration.

While emotional and liability concerns are often at the forefront of a clinician's thoughts when making an admissions decision, a magistrate would not be subject to these influences. It is unlikely that a magistrate would have had an interaction with, and formed a personal opinion of, the subject of the proposed order. Additionally, magistrates are free of the liability concerns that burden clinicians. They are thus far better situated to conduct a neutral analysis of the need for an emergency commitment.

iii. The evaluation preceding a commitment order is often based on faulty information.

Because of the legal standard, the determination of whether a person is involuntarily committed will frequently be based upon information which is insufficient, unreliable, or both. The statutory language is vague, allowing clinicians considerable interpretive latitude; moreover, it does not require either a clinical evaluation or even a conversation with the subject of the commitment order.

A clinician may order admission to a psychiatric facility if he or she has "reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness." Mass. Gen. L. ch. 123, § 12(a) (Pet. 33a). Thus, the critical threshold is simply *any* basis for the belief that failure to hospitalize

would create a likelihood of serious harm. The statute does not require the clinician either to consider all available information or even to attempt to confirm his or her belief. The frequent result is needless hospitalization based upon a partial, even misleading, picture, as the information is insufficient to portray the reality of the situation.

Two recent examples demonstrate this problem. In January 1995, upon deciding that Brenda's participation in a day treatment program should be ended, the program's psychiatrist ordered her committed. The psychiatrist and two other clinical staff had previously speculated that, upon being informed that her treatment at the program would be ending, Brenda would respond negatively and require hospitalization – but they did not inform Brenda of this theory. In fact, Brenda would have been relieved by the news that her participation in the day program was ending.

The psychiatrist apparently thought, based upon his speculation about the likely consequence of the termination, that the standard for signing a pink paper – "reason to believe" – had been met. By failing to elicit the correct information, the psychiatrist had incorrect facts on which to draw his conclusion. If Brenda had enjoyed access to even the most minimal judicial evaluation prior to the carrying out of the admission order, the staff's hypothesis could have been explored and Brenda could have offered her response.

In February 1996, a visiting psychiatrist, meeting with Deborah for the first time, concluded after ten minutes that she was depressed and admitted her to a private

psychiatric facility pursuant to a section 12 order. As Deborah explained to the hospital staff, however, the loss of two brothers in a single year had prompted her to contemplate and speak of death, while the deprivation of companionship brought on feelings of loneliness and boredom. The hospital staff quickly agreed that she was not suicidal. Thus, while the visiting psychiatrist apparently concluded that she had "reason to believe" that Deborah met the section 12 standard, a more complete review of the facts indicated otherwise.

Other language of the commitment statute further encourages decisions based upon insufficient and unreliable information. First, clinicians have broadly interpreted the terms "emergency" and "refusal . . . to consent to such examination", Mass. Gen. L. ch. 123, § 12(a) (Pet. 33a), to encompass a wide range of situations. But some situations are clearly not urgent, and some refusals of examination do not constitute a formal request and response.

For example, the December 1995 morning before Susan's appointment with a new psychiatrist had been eventful and stressful, in part due to the houseful of workers whom she was supervising; with a tremor in her voice, she called to reschedule. The psychiatrist signed a section 12 order, and directed the police to bring her in. After they entered Susan's house uninvited through an unlatched screen door and informed her that she was going to the hospital, Susan went willingly, initially believing that a family member had been involved in an accident.

By signing the pink paper, the psychiatrist must have concluded that an emergency existed. Susan had been referred to her to address possible psychiatric causes of difficulties in eating and sleeping. Earlier in the month, Susan had explained that to the psychiatrist's associate, a social worker, and had also clearly stated that she was not suicidal. While Susan's voice may have trembled on the telephone, that fact and the request to postpone do not reveal the existence of a present emergency. Her psychiatrist had taken a liberal interpretation of the term "emergency".

Secondly, a clinician's right to sign a commitment order without an evaluation and solely "on the basis of the facts and circumstances", Mass. Gen. L. ch. 123, § 12(a) (Pet. 33a), creates an obvious opportunity for mistakes and abuse. As demonstrated by the instant case, *see* 77 F.3d at 542 (Pet. 3a-4a), and by Annette's story, the clinician signing the commitment order may never speak with the subject of the order, but instead relies solely on second-hand information. And, the lack of a personal evaluation eliminates the patient's ability to confirm or dispute the facts and circumstances supporting the conclusion of likelihood of harm. For example, in Susan's case, the psychiatrist never discussed her condition with Susan, but, presumably, only spoke with the social worker. If the psychiatrist had spoken with Susan prior to instructing the police to bring her in, she might have learned that Susan did not pose a likelihood of harm. She might also have learned that Susan postponed her appointment in part because she hesitated to leave the workers alone in her house.

The issue of this case is whether the Fourth Amendment permits the warrantless search of a residence solely on the signature of a clinician. The examples presented in this brief are not intended to illustrate the inadequacies of the Massachusetts involuntary commitment scheme, but, rather, to show why a clinician's signing of a pink paper is not sufficient to meet the Fourth Amendment's prohibition against unreasonable search and seizure. In the absence of the detached perspective provided by a legally trained magistrate, section 12 orders must inevitably lead not only to improper commitments, but also to armed police entering a private dwelling without a warrant.

Rose Zinger died not because of a section 12 order, but as a result of such a forced entry. The above examples demonstrate why an intrusion of that nature should not flow automatically from a clinician's decision to sign a pink paper.

CONCLUSION

For the reasons stated in this and in the brief for the petitioner, the Court should grant the petition for review.

Respectfully submitted,

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JENNIFER HONIG

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